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ABSTRACT

The pilot Ecumenical Child Health Project tested ways to coordinate local church activities aimed at improving young children's access to health care. Within a year, coordinators at 3 pilot sites had succeeded in initialing or enhancing several activities that linked health care to more than 1000 families and children living in medically under-served neighborhoods. This article discusses strategies or approaches that emerged from the project as church-related routes for improving health access. The article also describes specific partnerships initiated between ecumenical groups and local organizations, and discusses limitations and advantages of working with churches to address child health concerns. While the pilot study demonstrated that child health is a viable mission for local churches, the paper suggests that resources, planning and technical assistance be coordinated on a community-wide basis. (JPB)

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RESOURCE BRIEF September 1995

The Role of Local Churches in Promoting Child Health: Lessons from Research and Practice

Karen N. Bell

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The **NATIONAL CENTER FOR CHILDREN IN POVERTY (NCCP)** was established in 1989 at the School of Public Health, Columbia University. Its mission is to reduce the number of young children living in poverty in the United States, and to improve the life chances of the millions of children under six who are growing up poor.

The Center:

- Challenges policymakers and opinion leaders to reverse the adverse consequences of poverty on young children.
- Alerts the public to demographic statistics about child poverty and the serious impact of poverty on young children, their families, and communities.
- Designs and conducts field-based studies to clarify which programs and policies work best for young children and their families living in poverty.
- Disseminates information about early childhood care and education, child health, and family and community support to inform state and local government officials, private organizations, and child advocates.
- Brings together public and private groups to assess the efficacy of current and potential strategies to lower the young child poverty rate.

NCCP's publications program is funded largely through core grants from the Ford Foundation and the Carnegie Corporation of New York.

Karen N. Bell is NCCP's former Associate Director for Child and Family Health. Much of her health care program and policy work has involved analyses of manpower, training, and organizational issues in the United States and in developing countries. After earning a master's of public health degree from Columbia University, she spent eight years at the National Research Council directing health policy studies and managing a program on international collaborative health services research. Her recently completed projects at NCCP include authoring a monograph entitled *Caring Prescriptions: Comprehensive Health Care Strategies for Young Children in Poverty*, which features eleven model programs; and directing the Ecumenical Child Health Project, which assisted ecumenical organizations in low-income neighborhoods to improve access to health care for young children.

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New Mexico Conference of Churches
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National Council of Churches of Christ
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Enhancing Child Health Access Through Ecumenical Groups and Churches

Policymakers and child advocates acknowledge that shrinking federal budgets and increasing poverty rates call for new partnerships to meet the needs of young children living in poverty. News accounts cite inspiring church-led efforts to care for the sick and to revitalize neighborhoods. Community organizations serving the poor debate how to strengthen the role of churches in filling the service gap left by federal and state agencies.

A pilot project recently completed by the National Center for Children and Poverty and the National Council of Churches of Christ demonstrates how three local ecumenical agencies worked to address child health needs—with mixed success. Their experiences offer some lessons about ways that churches can help promote the health of young children.

A national survey conducted prior to the project, pointed to multiple examples of local churches' work: operating soup kitchens and feeding programs, supplying volunteers for immunization campaigns, sponsoring health clinics, and housing child care centers and summer camps.[1] Other national data showed that churches receive the majority of charitable giving by individuals, and close to 40 percent of Americans say they attend church or synagogue regularly.[2]

Building on these findings, the pilot Ecumenical Child Health Project (ECHP) tested ways to coordinate local church activities aimed at improving young children's access to health care. A grant from the Robert Wood Johnson Foundation enabled the project directors to provide technical assistance and to fund modest start-up costs to ecumenical organizations in three communities: the Council of Churches of Greater Bridgeport, Inc., the Greater Dallas Community of Churches, and the New Mexico Conference of Churches.

Within a year, coordinators at each of the three pilot sites had succeeded in initiating or enhancing several activities that linked health care to more than 1,000 families and children living in medically underserved neighborhoods. Two of the ecumenical agencies secured outside grants to support the project, while the third appealed for general funding through its mailing list. By the end of the project, at least two congregations in each community had worked together on a child health initiative, and many church members were more aware of the needs in their communities.

Strategies for Improving Child Health Access

Three distinct strategies or approaches emerged from the project as church-related routes for improving child health access:

- ***Brokering direct services for child health needs.*** The first approach evolved at the ECHP pilot site in Albuquerque, New Mexico. Here the project coordinator first acted as a "listener," assessing the needs of health care organizations and identifying the skills of volunteers recruited from local congregations, and then served a "broker," creating a match between the two. Volunteer tasks arising from the "listen–broker" approach were varied. They included home visiting to families with newborns, presenting good-nutrition puppet shows in clinic waiting rooms, organizing a baby-clothing cabinet at a children's health clinic, calling new mothers of high-risk babies born in a local hospital to find out whether they would benefit from a visit by a public health nurse, delivering food to a Native American emergency food center, and calling rural churches to publicize the arrival of an immunization van in remote communities. The health providers were responsible for training and supervising volunteers.

  The "listen–broker" approach required neither intensive administrative effort nor long planning periods. Volunteers were recruited from churches and placed in useful positions in the neighborhood in a relatively short span of time.

- ***Recruiting and training volunteers to link families to health services.*** The second approach, used by Dallas, Texas, relied more on traditional methods of "recruiting, motivating, training, and supervising" volunteers. The Dallas site coordinator, an ordained minister, used her existing network of

(continued on page 5)

Recognizing Pastors' Perspectives

To obtain a national perspective on how active churches have been in promoting child health, the National Center for Children in Poverty and the National Council of Churches of Christ conducted a survey in 1990 of pastors from local churches representing sixteen major Protestant denominations. Responses from 1,883 pastors revealed widespread concern about child health needs and documented an array of health initiatives that local congregations were undertaking. Pastors reported a variety of serious health concerns in their communities, with substance abuse, teen pregnancy, and lack of health insurance topping the list. See table below.

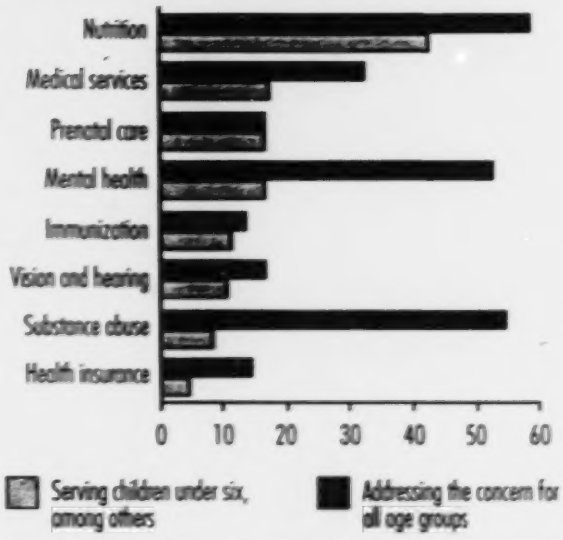
Perception of health problems by pastors

Specific health problem	Perceived as serious in the congregation	Perceived as serious in the community
Alcohol abuse	50 %	88 %
Drug abuse	33	83
Teen pregnancy	22	72
Lack of health insurance	36	68
Poor mental health	39	67
Poor nutrition	19	53
Inadequate prenatal care	8	45
Lack of medical services	19	41
AIDS	14	3
Low birthweight	8	30
Infant mortality	6	25

The survey also documented that more than half of all churches sponsored activities that benefited children under six for at least one health or nutritional need.[3] These were often conducted in collaboration with other congregations or public health agencies. These types of activities, on behalf of children, among churches of all sizes and denominations and between churches and health agencies, became the primary focus of the Ecumenical Child Health Project reported on in this resource brief. See figure above right.

While the findings of this survey and other studies highlight the multiplicity of community roles for churches, they also underscore the limitations that many congregations have. More than half of the

Percentages of churches serving children under six, by health concern



respondents reported a total church membership of 260 or less, a figure that corresponds to national figures.[4] These congregations, sometimes made up of aging populations, are less likely than others to have a full-time pastor, and they consequently cannot devote much staff time to programs that serve the community. Generally, reported activities are oriented toward adult health needs, such as counseling, referrals, education, and support groups, rather than toward child health needs such as advocacy, health screening, or treatment. Only 15 percent of the churches in the survey sponsored a child care program, and the percentages of churches serving children under six were low. See figure below.

Activities supported by churches in response to health concerns, by type of activity

Health activity	Percentage of churches involved in activity
Counseling	55 %
Referrals	48
Education	43
Payment for services	39
Support groups	30
Advocacy	22
Transportation	21
Screening	16
Treatment	7

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(continued from page 3)

relationships with pastors, lay church women's groups, and volunteers who had participated in child advocacy projects, to enlist new volunteers and identify congregations who had missions serving children. She spoke on Sundays and evenings to tell congregations about the project, conducted training sessions, and placed volunteers in existing church projects that fed children and families—so that they could help families know where and how to obtain preventive health care services.

The aim of the Dallas site has been to develop a cadre of committed congregational volunteers to serve as "health mentors" for low-income families in the community.[5] Volunteers are supported by individual congregations and supervised by the ECHP project, which develops formal referral relationships with health and social service agencies through an advisory committee.

- ***Providing incentives to congregations to add a health component to ongoing programs.*** A third approach, developed by the Greater Community of Churches of Bridgeport (GCCB), was first to promote networking between community church and health leaders in monthly brown bag lunch meetings. This regular interaction, with speakers and discussions, increased the awareness of pastors and lay leaders about child health opportunities and needs. The GCCB then offered "mini-grants" of several hundred dollars each to congregations in the target neighborhood.

  Of the four congregations who received grants, one helped a parish nurse to add children's health to her ongoing work with the elderly; another paid for lunches at the church so that low-income mothers from the neighborhood could get together and talk about health and childrearing concerns; and a third provided stipends for church leaders to act as health resources for the many families with children who attended community suppers sponsored by churches.

Developing Community Partnerships

These three ecumenical groups initiated specific partnerships with local organizations serving children and families. The partnerships often developed after the project coordinator's discussions with local agencies about agency needs and about ways churches could link families to services, or help mothers with small children address their health and nutrition needs. In some cases the partnership led directly to a successful joint application for outside funding.

Several of these partnerships are described below.

- ***Home visiting initiative with a health clinic.*** The New Mexico Conference of Churches recruited more than 20 volunteer home visitors from local congregations. Trained by health professionals from a University of New Mexico clinic, they were assigned to mothers with newborns in the target neighborhood. Staff met with them monthly and encouraged the volunteers to reflect on their experiences and provide insights for future planning.

- ***Assessment of immunization barriers at a WIC* office.*** The Greater Community of Churches of Bridgeport (GCCB) and the local WIC office submitted a successful joint grant proposal to the Connecticut State Medical Society. Project support enabled the GCCB to place a part-time worker in the WIC clinic to examine immunization records for infants and toddlers and to talk to families who were missing shots. The worker found that some physicians did not always fill out the WIC forms, and that some families felt intimidated or did not understand what the physician was saying, thus missing immunization opportunities. This collaboration contributed to improving the content of health messages for families with young children and led to the joint sponsorship with the health department of an immunization clinic just prior to school opening in the fall.

- ***Community outreach with a primary care organization.*** Volunteers from the Dallas pilot conducted immunization clinics and helped local churches organize child health and benefit fairs in Pleasant Grove, a neighborhood that formerly lacked pediatricians. They informed families about a new clinic sponsored by Parkland Hospital's Community

* WIC is the federally funded Special Supplemental Food Program for Women, Infants, and Children.

Oriented Primary Care Program. Parkland then invited local clergy and the ECHP coordinator to serve on a community advisory council.

Sites Discover Limitations

Within a short time, the three project sites succeeded in launching several community-based initiatives that facilitated health care for children. Project coordinators sought clergy support, recruited volunteers from local churches, and developed relationships with local health care and social service organizations. The sites eventually concentrated their efforts on community outreach, on programs for mothers with infants, and on adding health components to ongoing church programs. They discovered that finding volunteers for one-time events was easy—when compared to longer-term strategies for helping families in need.

Specific observations in the three communities may help to explain this result:

- Churches perceive child health concerns differently, depending on the specific neighborhood, and they develop different responses. In Dallas, the target neighborhood did not have a single health care provider who would see children without health insurance, and many families were not eligible for Medicaid. In Bridgeport, providers and church leaders believed that parenting problems, including drugs, violence, and apathy, were preventing children in low-income families from receiving health care. In Albuquerque, high mobility in low-income neighborhoods, including large numbers of new immigrants, inhibited mothers with preschoolers from learning about and enrolling in health clinics. Each pilot site identified key barriers to local health care and found partners to help address them.

- Churches can be excellent sources for recruiting volunteers for community-oriented activities—provided one or two members are highly committed to the specific cause, and if the effort has prestige and visibility. A 1994 immunization campaign in Atlanta, for example, relied heavily on church-based organizing, but also counted on established communications networks developed by The Atlanta Project. In contrast, two of three ECHP sites had more success recruiting volunteers for ongoing commitments through channels outside of churches, such as other service organizations, than within the congregations. To augment volunteer and staff efforts at outreach and networking, two pilot sites raised funds for stipends to community service workers. The Greater Dallas Community of Churches subsequently applied for and received a grant for AmeriCorps, the National Community Service Program. Fifty AmeriCorps members were hired, with 13 assigned to child health efforts in five low-income neighborhoods of Dallas.

- Low-income families will accept help from churches even when they feel isolated from other institutions in society. As the Bridgeport ECHP site reported after a successful immunization and health screening event, young mothers with limited education are "afraid of asking a busy physician questions," and they miss opportunities to learn about the preventive services their children need. Other families, who may not be legal residents, avoid the formal enrollment procedures of clinics but trust services offered through a local church. Still other families may be living doubled-up with relatives or friends, and may not feel stable enough to enroll their children in a health clinic. Such families, however, may seek clothing and food from churches, where volunteers can ask about the health status of their children.

- Health care and social service providers welcome the opportunity to become acquainted with ecumenical agencies and local congregations. Representatives from these agencies participated actively in meetings organized at project sites, and they spoke to church groups about community health problems. While local health departments do not always have the resources to provide the full range of primary health care services for children, they do take responsibility for assuring immunizations and referrals for children.[6] Relationships with local congregations can facilitate these tasks for health clinics, which often refer families to church-based programs or ask churches for assistance with immunization campaigns.

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Local Ecumenical Approaches Have Many Advantages

Local ecumenical agencies can be effective vehicles for enlisting the support of churches in addressing child health concerns. Regardless of their formal organizational auspices, they usually welcome support from all churches and faith congregations. They draw membership widely from the community, and often have ties to the more established churches and voluntary agencies. Whether or not they provide services, they enjoy community recognition and are usually regarded as neutral with respect to religious issues. Ecumenical agencies also have nonprofit legal status, and as umbrella organizations they can house new initiatives easily. Unlike individual churches, they can hire staff quickly without the long delays associated with congregational committees.

Nationwide, there are approximately 600 local and regional ecumenical and interfaith councils of churches, along with hundreds of other ad hoc coalitions of clergy and congregations. Local ecumenical agencies vary greatly in terms of their size, composition of membership, and missions, but they share common features such as scarce resources, flexibility, acceptance by local churches well beyond their formal membership, and high prestige in the community. In general, their membership is composed of established churches located throughout a geographical area, but may not include smaller, newer congregations. Some of them receive much of their support from local member churches, while others, like the New Mexico Conference of Churches in Albuquerque, are supported through appropriations from national denominations. Their approach to service and advocacy also varies. Many of the ecumenical or interfaith coalitions formed to address specific issues have undertaken community-based service programs focused on children.

Local ecumenical organizations can serve as brokers, not only between providers and individual churches, but among providers who are working in the same community. At one of the pilot sites the local WIC director and the Medicaid director became acquainted for the first time as members of the ecumenical child health advisory committee, and only then realized that they could improve services by collaborating. The ecumenical agencies soon realized, however, that playing an effective brokering role over the longer term would require resources and access to technical knowledge and policy advice. Generating such resources solely from local member congregations would be difficult, given the competing priorities in many communities of hunger, homelessness, and drug and alcohol abuse.

Learning from Project Experience

The Ecumenical Child Health Project demonstrated that child health, broadly conceived, is a viable mission for local churches, provided that resources, planning, and technical assistance are coordinated on a communitywide basis. It also highlighted the role of local ecumenical and interfaith organizations in launching new initiatives focused on children and families. These organizations, however, lack the technical expertise and resources to design and sustain church-based initiatives in child health without substantial backup from local health care providers and universities or even a national organization.[7] For a number of reasons, national church organizations are unlikely to provide such backup for local ecumenical efforts.

While many local churches see their mission as serving the community, national Protestant denominations and the Catholic church are struggling with dwindling membership and reduced financial contributions. In some denominations, politically divisive struggles have diminished the contributions they receive from local congregations. As a result, their national offices have reduced their staffs and decreased charitable and relief operations in the U.S. and overseas. At the same time, patterns of church attendance are changing, as many families search for a congregation that meets their needs and lifestyle.

Over the past decade, evangelical and charismatic churches have grown rapidly in membership, along with a few hundred "megachurches" that serve younger congregations with a mixture of entertainment and service programs more focused on the needs of members.[8] Overall, trends in religious participation forecast an increasing emphasis of churches on the local needs of their members and communities, rather than attention and support for

nationally defined issues such as the environment, welfare reform, and health care.

The increasing decentralization of churches does not reduce their potential role in promoting child health and access to health care; rather, the trend makes efforts to systematize or channel that role toward specific solutions more difficult. As the ecumenical pilot projects discovered, transforming the concept of "child health and access to health care services" into an appropriate mission for local churches was difficult.

Traditionally, church-based efforts to help families have focused on meeting immediate needs of food, clothing, and shelter, rather than on helping them locate preventive services and arrange benefits from the state. Each of the ECHP pilot sites had to translate child health into priorities for emphasis and specific action plans that made sense for their communities and the capacities of member churches. They succeeded in the short term in organizing child health initiatives, but they were unable, given limited start-up support, to develop a long-term funding base with local congregations or to create a solid program strategy to channel volunteers' energies.

In summary, child advocates and health care agencies need to consider resource requirements carefully in attempting to enlist individual churches as partners in addressing the health needs of low-income children. Initial investments in local ecumenical agencies might strengthen the capacities of individual churches—and may over the long term contribute to the improvement of child health on a community-wide basis.

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Ecumenical Child Health Resources

Interfaith Health Program
The Carter Center
One Copenhill
Atlanta, GA 30307
404-614-3757

Church Women United
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Washington, DC 20002
202-544-8747

Health Ministries Association
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Poland, OH 44515-1515
800-852-5613

Ecumenical Child Care Network
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Park Ridge, IL 60068-1456
708-298-1612

Children's Defense Fund
Religious Affairs Division
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